c. Distinct Part Rehab Units

Title XIX Charges x Operating Ratio x (IV - 0.2)

2. Special Pools

In addition to the regular DSH pools of $45,000,000, the Medical Services Administration is establishing the following special pools:

a. Separate DSH pools will be created annually for geographic areas covered by an Indigent Care Agreement (ICA) approved by the Director of the Medical Services Administration. Each pool will be established based upon local funds transferred to the state by one or more counties specifically for this purpose, the proportionate share of state dollars appropriated for such purposes for the geographic area covered by the ICA, and federal financial participation funds. Pool size will be determined annually.

DSH payments will be made to hospitals with approved ICAs between themselves and non-governmental entities established to provide medical care for the indigent population in eligible counties. Counties where approved ICAs exist will be excluded from participation in the State Medical Program (SMP). An approved ICA must include, at a minimum, provision for medical services for those individuals who would otherwise qualify for coverage under the SMP. Medical services provided under an ICA must equal or exceed that provided by the SMP.

One quarter of the annual payment to eligible hospitals participating in an approved plan will be made at the beginning of each state fiscal quarter. To be eligible, hospitals must meet minimum federal requirements for Medicaid DSH payments (found earlier in this section) and have an approved ICA in place. The DSH payment ceiling must be specified in the ICA. Local funds must be transferred to the state before a payment based on local funds will be made to a hospital.

b. A pool of $44,012,800 to be paid to DRG reimbursed hospitals during the state fiscal year 1999. The size of the pool is contingent upon receipt of up to $15,026,700 from Wayne County to be used as the state share of the payment. If Wayne County provides less than $15,026,700, then the pool will be reduced proportionately.

Eligibility for the pool is based upon data from the same base period used to compute the regular DSH payments. Like other DSH pools, eligibility for this pool is governed by Medicaid policy regarding merged hospitals.

To be eligible for this pool, a hospital must:

- meet the DSH eligibility requirements specified in Section III.H,

- not be receiving any other Michigan Medicaid special inpatient hospital DSH payments,
- have at least 25% indigent volume in its DRG reimbursed units.
- Have at least $20 million remaining under its DSH ceiling after the regular DSH distribution has been made, but prior to any distribution from this pool.

Freestanding children's hospitals will not be eligible for distribtuions from this pool. Distribution of funds from this special DSH pool will not preclude any hospital from receiving its share from the regular $45 million DSH pools.

The pool will be distributed equally to all eligible hospitals (e.g. if five hospitals qualify, then each will receive one-fifth of the pool). Payment to an eligible hospital will not exceed the hospital's DSH ceiling minus any payments from the regular DSH pools. Any payment not made to a hospital due to this limit will be distributed equally to the remaining hospitals.

c. The Medical Services Administration (MSA) is creating a special DSH payment pool of up to $5 million. The pool will be renewed annually at the same level.

The purpose of this pool is to:

- Assure continued access to medical care for indigents, and
- Increase the efficiency and effectiveness of medical practitioners providing services to Medicaid beneficiaries under managed care.

The MSA will approve one (1) agreement statewide with specific funding amounts each state fiscal year. To be eligible for the pool, a hospital must meet the following criteria:

- Meet the minimum federal requirements for DSH eligibility listed in Section III.H.
- Have in place an approved agreement between itself and a university with both a college of allopathic medicine and a college of osteopathic medicine that specifies all services and activities to be conducted using the funds provided through the agreement.

d. The MSA will annually create a separate DSH pool to fund indigent care. Participation in this pool will be limited to children's hospitals in counties with populations greater than two million. In order to participate, a hospital must have an agreement with the program approved by the Deputy Director for MSA. A hospital's DSH ceiling must be specified in the approved agreement.

Counties where separate, approved Indigent Care Agreements (ICA) exist will be responsible for the provision of indigent care in their counties.

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To be eligible to participate in this DSH pool, hospitals must meet federal requirements for Medicaid DSH payments. Minimum federal requirements may be found in Section III.H. A proportionate share of state dollars used to fund the State Medical and Indigent Care Programs and based on geographic coverage will be appropriated for this purpose. Payments by MSA to hospitals participating in this pool will be made at the beginning of each quarter. Pool size and included counties will be determined annually.

I. Capital

The initial reimbursement for capital will be paid as a separate Capital Interim Payment (CIP). CIPs will be made using a semimonthly schedule (24 payments per year). The CIP amount will be set using the most recent available cost data and an estimated impact of any applicable limits on capital. CIP amounts will be set annually at the beginning of the hospital's fiscal year. CIPs may be adjusted due to significant changes in capital costs that are not reflected in the most recent cost report.

After the end of the facility's fiscal year, the total amount paid under CIP is compared with total capital cost as reported on the filed cost report for that year less any capital limits that apply. Differences are gross adjusted.

If a hospital has a separate distinct part psychiatric unit, separate CIPs, comparisons to actual costs and determination of appropriate limits will be made for the distinct part unit and the balance of the inpatient hospital.

The Medicaid share of allowable capital costs is determined using Medicare Principles of Reimbursement.

The limits on capital described in this section apply for fiscal years beginning on and after October 1, 1990. The net licensed beds days calculation for hospitals whose fiscal year begins after September 30, 1990 and before January 1, 1991 and that reduce their licensed bed capacity by delicensing beds or using the rural banked beds option before January 1, 1991 will be made as if the reduction occurred on October 1, 1990.

Net licensed beds are used to determine net licensed bed days for capital reimbursement and include all beds temporarily delicensed, except for rural banked beds, with rural as defined under section 2 below. Net licensed bed days are:

Total Licensed Bed Days - Rural Banked Bed Days

A hospital may apply for a reduction in net licensed beds days to subtract bed days unavailable due to construction or renovation. Such a reduction is only available for beds which are taken out of service for construction or renovation for a limited period of time and which are returned to active inpatient service at the end of the construction or renovation project. Documentation of the construction or renovation project will be required.

Occupancy is:

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$$\frac{\textit{Total Inpatient Days (Including Nursery Days)}}{\textit{Net Licensed Beds Days}}$$

1. Sole Community Provider Eligible Hospitals

   If the hospital is eligible for sole community provider status (as defined by Medicare standards), the Medicaid share of allowable capital costs is reimbursed in full.

   The Medicaid share of allowable capital costs of any distinct part psychiatric units in sole community provider eligible hospitals is reimbursed in full.

2. Rural Hospitals

   If a hospital is located in a rural area (defined as located outside a city of 40,000 or more people by a distance of 10 miles or more and based on U.S. Census Bureau population data) capital reimbursement will be limited if occupancy in the hospital is less than 60% during the hospital's fiscal year. For hospitals with occupancy less than 60%, the Medicaid reimbursement for capital will be:

$$\frac{\textit{Occupancy}}{0.6} \times \textit{Medicaid Share of Capital}$$

   If occupancy is at least 60%, the Medicaid reimbursement for capital will be 100% of the Medicaid share of Capital.

3. Other Hospitals

   If a hospital is not eligible to be a sole community provider and is not located in a rural area, capital reimbursement will be limited if occupancy in the hospital is less than 75% during the hospital's fiscal year. For hospitals with occupancy less than 75%, the Medicaid reimbursement for capital will be:

$$\frac{\textit{Occupancy}}{0.75} \times \textit{Medicaid Share of Capital}$$

   If occupancy is at least 75%, the Medicaid reimbursement for capital will be 100% of the Medicaid share of capital.

4. Hospitals Outside of Michigan

   Medical/surgical hospitals not located in Michigan receive a per case add-on amount to cover capital cost.

   Freestanding psychiatric hospitals and distinct part psychiatric units of hospitals not located in Michigan receive a per day add-on amount to cover capital cost.

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The add-on amounts are an estimate of the statewide average paid to hospitals located in Michigan. Capital payments to out-of-state hospitals are not cost settled.

J. Graduate Medical Education

The total annual Medicaid medical education payment for academic year (AY) 1997-98 (from July 1, 1997 to June 30, 1998) and AY 1998-99 will be set not to exceed the total payment made for graduate medical education in calendar year (CY) 1995.

Formula Payments to Hospitals for Health Professions Education
Payments will be made directly to hospitals by formula from two pools of funds. Payments will be fixed, prospective payments, made in full, not subject to future cost settlement, or appeal. Payments will be made only to hospitals which provide requested information by the dates required.

Historical Cost Pool
Payments to hospitals from the historical cost formula pool will be based on:

1. an estimated settlement of direct medical education for hospital cost years ending in CY 1995, and
2. a calculation of the estimated indirect medical education based on inpatient discharges that occurred, and outpatient services provided, during CY 1995.

For AY 1997-98, payments from this pool will total $166.3 million. Semi-monthly payments (24 payments during the academic year) will be made to hospitals which have submitted required reports by April 1, 1997. Settlements for direct medical education for hospital cost years ending in state FY 1997, other than June 30, 1997, will involve split year settlements.

Primary Care Pool
A primary care formula pool will be established. Payments will be distributed to eligible hospitals based on the following formula:

1. The number of full-time-equivalent (FTE) primary care interns and residents drawing salaries at each hospital will be multiplied by one plus each hospital's Medicaid volume factor (taken from the hospital's indigent volume report).
2. The product for each hospital from the above step will be divided by the sum of the individual products for all hospitals from step 1.
3. The result for each hospital from step 2 will then be multiplied by the primary care pool to determine each hospital's share of the pool.

For AY 1997-98, the primary care pool is to be $20 million. The first payment from this pool will be made in July, 1997. The last payment from the pool will be made no later than June 1998. Payments will be made semi-monthly (24 payments during the academic year).

For purposes of distributing the primary care pool, primary care positions are defined as those interns and residents pursuing graduate medical education in general practice, family practice, general internal medicine, general pediatrics, internal medicine/pediatrics, preventive medicine, obstetrics, and geriatrics. Countable positions will be those interns and residents in the first three

years of a primary care program that will lead to a placement in a primary care practice. In addition, the fourth year of GME may be included for internal medicine/pediatrics and obstetrics. Two years of training in geriatrics beyond the initial primary care program in internal medicine or family practice may be included. The initial year of an osteopathic or transitional rotation may be included also.

Required Reports from Hospitals Receiving Funds from the Formula Pools
To be eligible to receive a payment from the historical cost/primary care formula pools, a hospital is required to submit a report to the MSA each year. The reports shall include the following:

- A description of how the Medicaid funds from the pools are being used in the support of the "Guiding Principles of Medicaid Payment Policy for Health Professions Education"
- A list of all interns and residents by name, indicating the primary care or specialty care field in which each is training, the year of training for each, and the percentage of full time equivalent (FTE) salary allocated to that hospital, for the academic year July 1, 1996 through June 30, 1997
- Forms will be provided to the hospitals prior to February 1, 1997

Payments from the Historical and Primary Care Pools for AY 1997-98 will not be made to hospitals that do not submit the required information by April 1, 1997. To be eligible for payments in AY 1997-98 from the Historical and Primary Care Pools, hospitals must operate a GME program in AY 1997-98. Reports will be subject to field audit.

Grants for Innovations in Health Professions Education
To encourage the training of health professionals in managed care settings, a special pool will be established which may be distributed to a consortium of hospitals, universities, and/or managed care organizations that collaborate to provide or develop health profession training in managed care settings. On a competitive basis, incentive payments may be awarded to qualified applicants that respond to a request for proposal (RFP) issued by the Department.

Incentive payments will be awarded based on public policy goals and priorities. Eligible applicants for funding from this pool will include, at a minimum, a consortium including a hospital, university, and managed care organization, (and may also include a clinic, outpatient hospital clinic, federally qualified health center, rural health clinic, local public health provider or other providers) who can provide appropriately accredited training. Exceptions to this requirement may be made in the case of training programs in which participation by a hospital is not required for accreditation (e.g. a graduate nurse training program). Incentive payments will be awarded only for professional education programs that are accredited by national and/or regional accrediting agencies. An enrolled Medicaid provider must be included in, and the treatment of Medicaid patients must be part of, any consortium awarded a grant. Payments will be made to the enrolled Medicaid provider which will act as the fiduciary for the consortium.

Incentive payments may be awarded for multi-year periods. In AY 1997-98, qualified bidders may apply for a planning grant or for a grant for the purpose of developing and implementing a specific innovative future training program responsive to Medicaid policy priorities, including developing new educational infrastructure for a system of training involving managed care arrangements.

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For awards to be made in 1997, it is estimated the Innovations in Health Professions Education Grant Pool will be set at $10 million. Incentive payments may be awarded up to a total of $10 million. Payments from this pool will be made monthly based on submitted expenditure reports.

IV. Appeals

A. Price Appeals

The MSA will consider appeal requests received within thirty (30) calendar days from the date of notice to the hospital advising it of a change in its pricing components. Appeal requests must be submitted in writing to the MSA. Requests must clearly state the item(s) being appealed, the remedy being sought, and must include all necessary documentation to support the hospital's position. Appeal requests received after thirty (30) calendar days will not be accepted. Appeal requests may not be used as a means to delay submission or fail to produce cost reports in the format and within the time frame required. Failure to include all necessary documentation to support the hospital's position may result in a hospital's appeal request being rejected.

Items subject to appeal include:

1. Interpretations and/or application of program:
   a) Policy
   b) Procedures
   c) Formulas
   d) Pertinent laws and regulations (e.g. Code of Federal Regulations, HIM-15, etc.)
2. Incorrect data and/or paid claims information used in price calculations – excluding data and paid claims information from the hospital's annual cost report previously submitted by it and accepted by the MSA.

Items not subject to appeal include:

1. Data previously submitted by the hospital and accepted by the MSA
2. The establishment and use of DRGs
3. The Medicare Principles of Reimbursement (e.g. 42 CFR, HIM-15, etc.) as adopted by the MSA and used to reimburse providers
4. The use of relative weights as part of the DRGs
5 Interim payment rates which are in compliance with state and/or federal regulations, and
6. Non-program related issues

Appeal requests must be sent to: Appeals Section, Department of Community Health, P.O. Box 30479, Lansing, Michigan 48909.

B. Appeal Process

Upon receipt of an appeal request, a bureau conference is scheduled and conducted by a MSA staff person from the Appeals Section. During this conference, issues related to the appeal are discussed by the MSA staff and hospital representatives.

Failure to appear at a scheduled bureau conference without good cause and reasonable advance written or telephone notification to the MSA staff person assigned to the appeal is considered an abandonment of the appeal.

After the bureau conference, a final determination notice is sent to the hospital outlining the MSA position on the item(s) appealed.

A price appeal decision may include a correction to the data used to set rates. If so, the corrected data is used beginning with the rate period for which the appeal was filed. Data corrections and any resultant price component changes which are accepted through pre-hearing conference or prevail at hearing are made for the current base period only for the hospital filing the appeal. The MSA may make changes to price components which affect all providers in subsequent rebasing periods.

Hospitals wishing to proceed to the next level of the appeal process have two options:

- The hospital may elect to appeal through an administrative hearing as provided in the department's administrative rules, R400.3406 through R400.3424. Administrative appeal requests must be sent to: Administrative Tribunal, Health Legislation and Policy Development, Department of Community Health, P.O. Box 30479, Lansing, Michigan 48909.

- The hospital may waive its right to appeal through the administrative rules, R400.3406 through R400.3424, and instead elect to request a hearing before the State Hospital Appeal Panel. A waiver statement, signed by a duly authorized representative of the hospital, must accompany the appeal request. Appeals to this panel must be sent to: State Hospital Appeals Panel Coordinator, Department of Community Health, P.O. Box 30479, Lansing, Michigan 48909.

Only issues raised at the bureau conference are accepted for review at either of the two hearing processes. Appeal requests must be received by the MSA within thirty (30) calendar days from the date of the final determination notice sent to the hospital subsequent to the bureau conference. Failure to submit an appeal request within thirty (30) calendar days shall be deemed an abandonment by the hospital of all further administrative appeal rights.

C. Administrative Hearings

Hearings conducted by the department's Administrative Tribunal follow the Department of Community Health's Medicaid Provider Reviews and Hearings rules found at R400.3406 through R400.3423.

D. State Hospital Appeal Panel

The State Hospital Appeal Panel shall consist of one member chosen by the hospital, one independent member (selected by the MSA from a list of prospective members supplied or approved by the hospital industry), and one representative of the MSA.

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The appeal panel coordinator shall schedule the times and places for the pre-hearing conference and the appeal panel hearing. Written notice of the hearing shall be mailed to the parties not later than thirty (30) calendar days from the date the appeal request is received by the appeal panel coordinator. The pre-hearing conference and panel hearing shall be held in Lansing. Failure to appear at a scheduled pre-hearing conference or hearing without good cause and reasonable advance written or telephone notification shall be deemed an abandonment of the appeal. Actions described in the final determination notice shall then be implemented without further notice to the hospital.

All time requirements for appeal to the panel may be extended by mutual agreement of the parties involved.

Each party must submit a position paper to the appeal panel along with all necessary documentation to support its position. In order to be considered, position papers and supporting documentation must be received by the appeal panel coordinator no later than fifteen (15) calendar days prior to the scheduled hearing date.

The appeal panel shall give each party an adequate amount of time to present its evidence and arguments. The appeal panel reserves the right to exclude testimony or evidence which it deems to be immaterial, repetitious, or irrelevant.

Each party is entitled to call persons to testify at the hearing.

A complete record of the hearing is made by a licensed Certified Electronic Reporter. The record may be transcribed and reproduced at the request of either party. The transcription cost is the responsibility of the party making the request.

The appeal panel may affirm, modify, or reverse a bureau conference decision upon the affirmative vote of two or more of its members.

The appeal panel shall issue a written recommendation no later than sixty (60) calendar days after the closing date of the hearing. The written recommendation shall include findings of fact and relevant conclusions of law.

The recommendation decision of the appeal panel shall be forwarded to the Director of the Department of Community Health with copies mailed to the hospital and appropriate MSA appeals staff.

Either party may file exceptions to the recommended decision. Exceptions must be filed within twenty (20) calendar days of the issuance of the appeal panel's recommended decision. Such exceptions must be submitted to the department director with copies sent to the opposing party and the appeal panel coordinator. Exceptions filed after 20 days will not be considered.

The department director may accept, modify or reverse the recommended decision of either the panel or the administrative law judge. The decision of the department director shall be binding unless the hospital wishes to appeal the decision to a court of appropriate jurisdiction.

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If an appeal results in a change which affects claims already processed, three alternatives to implement the change shall be available:

1. The hospital may elect to submit claim adjustments through the normal billing process.

2. The hospital may request an early initial settlement for the entire hospital. The initial settlement will incorporate the appeal decision in determining the gross program liability. Initial settlements are done only after the end of a hospital's fiscal year end.

3. The impact of the appeal decision may be incorporated into the hospital's final settlement process.